WISCONSIN MEDICAID
PERSONAL CARE ADDENDUM COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The Personal Care Addendum, HCF 11136, is a form that may be completed to supply additional information when requesting PA or for Wisconsin Medicaid recipients requesting an amendment to a PA request. The information on this form is mandatory. The use of this form is voluntary and providers may develop their own form as long as it includes all of the components requested on this form. If more space is needed, attach additional pages. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Retain the original, signed Personal Care Addendum. Attach a copy of the Personal Care Addendum to a copy of the recipient's plan of care (POC), any additional supporting materials that justify or explain the requested changes, and other documents as appropriate as directed by Wisconsin Medicaid personal care policy. Providers may submit PA documents to Wisconsin Medicaid by fax at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name — Provider
Enter the name of the Medicaid-certified personal care agency providing services to the recipient.

Element 2 — Wisconsin Medicaid Provider Number
Enter the Medicaid-certified personal care agency's eight-digit Medicaid provider number.

SECTION II — RECIPIENT INFORMATION

Element 3 — Name — Recipient
Enter the recipient's last and first names, and middle initial.

Element 4 — Recipient Medicaid Identification Number
Enter the recipient's Medicaid identification number.

SECTION III — GENERAL ASSESSMENT

Element 5 — Skilled Visits Required by Recipient
Enter an "X" next to all visits required by the recipient.

If the recipient is eligible for Medicare, cannot reasonably obtain services outside the residence, and requires a skilled service, Medicare must be maximized before claims may be submitted to Wisconsin Medicaid, including disposable medical supplies and durable medical equipment. However, providers should request PA for all Medicaid-covered services, including those billed to other payers.

Element 6 — Communication Capability
Enter an "X" next to the statement that most closely matches the manner in which the recipient makes his or her needs known.

Element 7 — Hearing Aide Usage
Enter an "X" to indicate whether or not the recipient wears a hearing aide.

If the recipient wears a hearing aide, enter an "X" next to the statement that most closely matches his or her ability to hear while using the hearing aide.

Element 8 — Vision Correction
Enter an "X" to indicate whether or not the recipient wears corrective lenses.

If the recipient wears corrective lenses, enter an "X" next to the statement that most closely matches his or her ability to see while using the corrective lenses.

Element 9 — Orientation
Enter an "X" next to the statement that most closely describes the recipient's orientation awareness to the present environment in relation to time, place, and person.

Element 10 — Medications
Enter all medications prescribed for the recipient. Include the dosage, frequency, route, and start and stop dates for each medication listed.

This information is required regardless of which provider or agency administers or assists with administration of the medications.

Element 11 — Supporting Rationale for Requested Increase of Units
Document the specifics and supporting rationale for the increase in requested units. Attach additional pages if necessary.

SECTION IV — SOCIAL INFORMATION

Element 12 — Social / Economic / Cultural Factors
Identify and explain any social, economic, and/or cultural factors of the recipient that may impact the need for personal care services or how the services are provided.

Element 13 — Scheduled Activities Outside Residence
Enter an "X" to indicate if the recipient attends regularly scheduled activities outside his or her place of residence.

If the recipient attends regularly scheduled activities outside his or her residence, provide the weekly schedule for these activities. Specify the times of day each activity takes place (e.g., 8 a.m.-3 p.m., school).

SECTION V — HISTORY OF CONDITION

Element 14 — Condition / Past and Present Problems Affecting Personal Care
Enter the recipient's condition and any past or present problems that directly affect the provision of personal care services.

SECTION VI — STAFFING SCHEDULE

Element 15 — Staffing Schedule of Each Agency or Provider Providing Services
Enter the scheduled times that each agency or provider provides services to the recipient and indicate the funding source. Staffing may vary on a day-to-day basis at the convenience of the recipient. Agencies/providers may not vary schedule times without the approval of the recipient. Specify the times of day each provider provides services. If the schedule varies, enter the schedule that most closely resembles the services usually provided (e.g., PCW 8am-10am, HHAide 10am-2pm, PCW 6pm-8pm).

Element 16 — Other Information
Document any other information that supports the need for personal care services and the justification for the time that is required to provide the services. Attach additional pages if necessary.

SECTION VII — SIGNATURE

Element 17 — SIGNATURE — Authorized Nurse Completing Form
The registered nurse (RN) completing this Personal Care Addendum is required to sign this form.

Element 18 — Date Signed — Authorized Nurse Completing Form
Enter the date that the RN completing this Personal Care Addendum signed the form.

Element 19
This element serves as a reminder that the recipient's POC must be submitted with the Personal Care Addendum.